Written evidence submitted by group 2 (Event 2) (EPW0082)

Transcript of roundtable event with members of the health care workforce held on Wednesday 11th May for the Health and Social Care Committee Workforce Expert Panel.

Group 2

Stephen Peckham: So we got 3 broad areas. You've been sent the information beforehand about the areas we would like to try and cover if we can. So we'll try and break it down into 20 minutes and then if we finish earlier, we can come back and pick up other things. Please feel free to interject as much as you like and I'll try and to make sure that everybody gets their time to contribute to the session, which, as Jane said, will contribute to the input to the final report that we do. So, I'm going to start first around the area of planning the workforce, and one of the key government commitments that was made is that the staffing level should meet the needs of the service, and please don't fall over yourselves, but I just be interested to hear your comments. I'm particularly interested to know whether there are particular shortages in particular areas which you might have knowledge of. If you can use the hand symbol or wave your hand, that would help me to pick you up. So Participant A, yes.

Participant A: Given the RCP's passion for the Health and Social Care Bill, I think if you don't know what the workforce need is, you can't really have anything to measure it against. In terms of specific things, I think numbers is really, really nebulous and looking at all our workforce census data, which actually the RCP does create quite a lot for doctors, is the increase amount of part-time working, this is mimicked across in trainees, everyone wants to work less, so the fact that we don't really collect very good data on what people are doing means that there is going to be a massive unmet need. There is already massive unmet needs and I think in the 12 years I've been training I've just seen rota graphs grow and grow. Sometimes we put names to them and that makes it feel good, then you think there is actually a person in that name called Elga or something, but realistically there's just gaps on everything and that means that everyone has to do 120% of their work time because it's an expectation that you fill the gaps.

Stephen Peckham: OK, thank you. Participant B, I think you were next.

Participant B: The Chartered Society of Physiotherapy believe that the staffing level government commitments haven't been met, as well as this commitment that your panel is currently focusing on, there's also commitments within the long-term plan that will improve patient outcomes and reduce demands on the most expensive parts of the NHS, such as improving expansion for people to access cardiac rehab, pulmonary rehab, stroke rehab, pelvic rehab; and other commitments, such as around discharge to access as well. For the NHS and government to be able to deliver on these commitments, it's heavily reliant on the expansion and numbers of physiotherapists, as well as support workers. As well as these commitments, there's other commitments that have come up due to COVID that urgently need more physiotherapists and support workers and these are priorities around clearing the elective care backlog, and also staffing COVID clinics as well. Expansion in physio staffing hasn't happened to match these policy commitments and as a result of this that is why we are currently seeing services being overstretched, people are missing out on appointments, and this, in turn, is impacting on people's conditions that are deteriorating and they're being pushed into more expensive parts of the NHS and social care as well. I just want to also touch on targets, the only workforce targets for physiotherapists are as part of the 26,000 targets for additional roles in primary care, which is 5050 first contact physiotherapists. The evidence clearly shows that FCP's are safe and effective in being the first point of contact for people contacting their GP practice with MSK

issues and that meeting this target will significantly relieve pressures on GP's as well as benefiting people and reducing demands on secondary care.

Stephen Peckham: Are you saying that that target has not been met?

Participant B: Yes.

Stephen Peckham: OK. Yeah. Just to kind of get it in black and white so that we're very clear about whether they are fulfilling commitments I think is quite important from our point of view. Thank you, Participant B. Participant C?

Participant C: Thanks very much. The Royal College of Pathologists cover 17 different specialties and all of whom, including the veterinary pathologists, are involved in human healthcare. We have consistent and persistent workforce shortages across all 17 specialties. And in terms of the government's target, we are of the view that it has not met its commitment in ensuring that there is adequate staffing. If you look at consultant workforce in the NHS, it's grown about 4% to 5% per annum, while in laboratories it's been less than 1% whilst the workload continues to grow and through COVID that has been really unmeasurable with the amount of work that has come, and the concern we have now is about the backlog, different departments but still the same specialties. So what we're seeing is McMillan today are saying that they've got 32,000 fewer patients started on cancer therapy. That's a bit of an underestimate according to our figures, and I think there's probably somewhere between 300,000 and 400,000 cancer biopsies that have not been taken and not been reported if you extrapolate the data that we have. As a group, the laboratories are less than 4% of the total budget in the NHS but reach into about 95% of hospital patient encounters. We have medical staff and pathology, and whilst there has been an increase to some extent in training numbers, this does not equate to the number of people who are going to retire, never mind allow us to increase the number of people there. Clinical scientists, there is an initiative in England in clinical science, but again, training programs are poorly funded, and for both of these - as we expand particularly in things like cancer care, towards increasing complexity of diagnostic procedures which allow us to help determine the appropriate treatment of patients going forward with specific markers - the laboratory time and the personal time involved in doing that continues to increase above the numbers of specimens that we get in. So, it's almost an exponential rise in expectation because of the increased complexity of what we do and the detailed information that's required above that. In addition, in laboratories we have biomedical scientists, and we have difficulties in staffing biomedical scientists too, and a lot of the last is particularly in places where they don't have degrees where biomedical scientists can be educated in undergraduate schools. So really across the piece we have a shortage of staff and an inability really to see a way through to increasing the numbers in a way that would begin to match the expectations upon us. And that's a huge concern for us, I think.

Stephen Peckham: Yeah, I mean, I certainly reflect some of the things we heard in the cancer review that we did, so thank you. Participant D, perhaps particularly thinking about the pledge around the 50,000 nurses?

Participant D: Yeah. I mean, obviously continued significant shortages of staffing, I suppose the 50,000 being I think more plucked as a figure rather than necessarily based on clear workforce planning is the concern. There's a real focus around international recruitment currently which feels very short-term in its approach and also challenging ethically as a workforce solution. I think the disinvestment from a point of view from nurse staffing and nurse education and development over proceeding 8 slow years, has meant we've got such a deficit that actually in order to recoup that it's

significantly on the backfoot to do with the workforce data that we get, its inaccurate a lot of the time from national systems, and actually when we're saying is it ensuring staffing to meet the needs of the service, the service just keeps expanding. I think one of our biggest concerns is lack of accurate data, lack of clear workforce data, lack of clear strategic workforce plan and leadership around that at a national level. Another example of that is, since commissioning students went for healthcare students, certainly from a nursing point of view, I can't speak on behalf of other professions, but it's been left to individual organizations to negotiate with local HCI providers. Well, as a system or as a service that's hugely inefficient and also does not allow us to clearly workforce plan, we're dependent on connecting with local universities, when actually this should be looking at this far more as systems, as regions, or what's the national demand and the long-term plan. Post-COVID, we've seen services change, escalate, and we don't necessarily have the rights nurses with the right skills to move into those sectors. Certainly my work on a national level, the shortage of nursing in the community sector for example is now having a significant impact on the ability for acute care to discharge patients who are medically fit but there's nowhere for them to go. There are no care homes. There's a lack of care because social care has lost so many staff with all the concerns around COVID vaccinations etc, already had a shortage of staff. So, I suppose that overall there's no confidence that there's a commitment to ensure safe staffing because it doesn't feel like that on the ground, irrespective of how the progress around that 40,000 or 50,000 target to bring more nurses in.

Stephen Peckham: Ok, thank you. Participant E, Participant B brought up the issue of the promised primary care workforce and I just wondered whether you had comments about the pressures and the primary care sector. I mean, Participant D just mentioned community nursing as well, but I didn't know whether you had anything to say.

Participant E: Yeah, I can echo everything that Participant B and Participant D has said. The problem for us, for all ambulance services, is that we're the one stop. If the GP's not picking up mental health services not picking up, let's ring 999. The funding is not there, and the commitments are not being met, especially around recruitment. But on the other side of that for us it's actually retention, so we've got masses of staff now that have done 20 years, and three years' worth of COVID, and have now said now "I'm done, I'm absolutely burned out". So, from my point of view, I'm losing it at both ends; I'm losing it from staff coming in that are qualifying as paramedics that are doing the five years, but actually if they do 10 or I'd say near of the nine year mark they're only staying in for four years and then finding other things to do predominantly anywhere but working with patients and that's concerning. But for me as well, it's the retention at the other end of and the amount of staff that I've got to that 15/20 year mark that are now saying I am done, it's that experience that will losing. And those staff, that will all know from the amount of time we've all put in, that actually have always gone the extra mile and actually done the extra hour and worked through the lunch break, and I don't see that with new staff. And that's where the holes are. You can see in time, and the flexible working as what Participant A said, we've got huge, huge amounts of staff that do not work full time. So, you've got constant holes.

Stephen Peckham: So I want to come back to wellbeing a bit later and things like retention. But I mean I picked up a few things like data training and staff planning are things that seem to be a common thread, but Participant C, you wanted to come in again.

Participant C: Yeah. Thank you. There's a couple of things. I was going to say a bit of a wellbeing and retention and other elements. But before I do that, one of the difficulties about data gathering is around the conditions that are set around the English trusts and foundational trusts particularly, and the lack of ability to require trusts to share data because they are said to be commercially sensitive. I

know this is this is relevant because coming from Scotland as I do where we don't have that, we can get data and we have data, and in Scotland we can use that data much more effectively because we know it sound in terms of workforce and workload, and in the laboratories in Scotland that is just about to come out the 3rd edition of the workforce across the entirety of laboratory services and the NHS in Scotland. So those data can be collected with the right ground rules and collecting the data requires people to hand over those data, and as I say, there is a model which works effectively around that. But I do think what everybody has said about the workforce and part-time working retention is really important, if you want to talk about wellbeing and stuff later that's fine, but the BMA has done quite a lot of work about why people want to retire, and I think those features go for less than full-time training by and large as well, less than full time working as well as why people want to leave. There are threads of similarity around about workload and working patterns, if you're an intensivist, for example, it's fine when you're 30, but when you're 60, doing huge, long stretches at night is not something which is physiologically sound to do. So, the requirement to people at different stages in their career and their work that's expected of them differs. So, I would like to spend some time talking about culture, working environment, facilities, and wellbeing, but we can come back to that later, but it is important because it's all on the same deal.

Stephen Peckham: Yeah, I totally agree. I mean, Participant A, training was mentioned, there's been the recent questions about insufficiency of training places as well, so that expansion of medical training and having difficulty in finding training places. Do you want to say anything about that?

Participant A: So, I think when RCP is pushing for double or quits that we increase the number of medical student places, and it is difficult when you see the foundation years have less allocation, however, I think most people do find spaces; changing around curriculums, our core medical training, switching to IMT. There's been lots of things about, “oh, there isn't enough space, there isn't enough space”, and suddenly there's too many spaces and then you end up with more rota gaps. So, switching around and doing different things often seems to make more problems of workforce shortages because people expand rotas and rotas get written and then there's gaps where people are dropping out. It needs more flexibility that if someone gets pregnant, someone transfers to another area, that the rota isn't just set in stone for six months, that there's now a gap in it, that it then flexes. But at the same time, people want flexibility that they get to choose their on-call days, that they're allowed to have a wedding, they're allowed to go somewhere, and it's really difficult to balance those two issues. But I think possibly the BMA thinks where we got to have our rota six weeks in advance is a helpful guide, but maybe we don't need the whole year six weeks in advance, because then there could be more flexibility and you don’t have to work with the with gaps.

Stephen Peckham: OK, thanks. Participant B, we're talking about national commitments, and I wondered if you wanted to pick up anything Participant D said earlier about well it’s all locally negotiated and organized and clearly that would be very true in your sector of work. Is there local planning or is it just around individual contracts?

Participant B: Yeah. So, for physiotherapists - and also, I'll talk about AHP as well and I'll be referring to AHP's as well when I'm talking - currently, the Health Education England HEE have provided trusts with short-term funding for AHP leaders to develop local AHP plans. And this is like a first-time thing, and we see it as a welcome step and it's long overdue, but it's critical that these are implemented and made a regular part of workforce planning, such as at trust level and ICS people board level. We see that more work is needed on integrating workforce planning in particular, such as across primary and community services, and currently this is being done in silos. The physio labour market is a UK-wide one and local planning alone will not ensure enough staff are being trained, are being

recruited, and we also need national guidance for workforce planning to implement all the national policies as well. So, we urgently need to set minimum AHP workforce targets for the next iteration of the people plan for both registered and non-registered support workers.

Stephen Peckham: Thank you, Participant C?

Participant C: Yeah. I think training is a big issue for us in pathology specialties. For example, HEE produced 34 new training posts in histopathology last year, and there are some haematology ones this year, just a couple. But the funding was only for a year and so organisations were then expected to find the funding to pay the people that we've just started, and the program usually is billed for five to five and a half years (the average is five years and ten months approximately), but it takes a while to train somebody. The same is true with clinical scientists, quite often it's left to local funding to try to fund clinical scientists in laboratories, and the training opportunities and support around about biomedical scientists again are left at local trust level. So, altogether the investment in training could be better because it doesn't satisfy the needs of the people we have, never mind the needs of the people we should have or could use helpfully going forward, which again just looking around the room, seems to me to be a generic issue across everything. And I wish I had an easy solution for it.

Stephen Peckham: OK. Participant B?

Participant B: Yes, just to follow on from Participant C, I just want to talk about training as well. As I reiterated a few times, there's a lack of physio workforce targets in community, which means there's not enough numbers overall and this has a knock-on effect also in the pipeline of physios gaining the experience and being able to develop and gain advanced practice skills that are needed to take on FCP roles, and also, we are having issues in regard to the backfill of when staff move into FCP roles. So, at the moment, we're seeing a strong supply of physio graduates, and there is a clear need for this, but this is not yet translating into NHS staffing numbers. We believe that services need to over-recruit Band 5's to be able to maintain numbers as physios move within the NHS services. So, at the moment we've got a healthy supply of registered physios, as I said, since 2012/2013 there's been a year-on-year growth of registered physios, and there has been a 64% increase in student intake since 2015/2016, and we expect that if pre-registration places remain the same then we can expect an annual growth in physios in the order of, let's say, 6%-7% per year over the next decade. We believe NHS England should be capitalising on the growth of all physio graduate numbers and that not doing so is missing a trick here. One way to be able to achieve this would be to offer NHS contracts to all newly qualified registrants as is being considered for nursing, as my colleagues have been saying. In some services they're also experiencing difficulties in establishing Band 6 physiotherapists as well. But I also just wanted to touch on support workers, as I always do, but we also need to recruit more support workers alongside registered physios and we need to recruit more of other non-registered staff as well, and we also need to implement higher-level role development for therapy support workers, including in supporting clinical education, exercise prescription, and coaching; and also widen access through apprenticeship programs for support workers to become registered physios where appropriate. This will, as I said, expand on non-registered staff physiotherapy and rehabilitation support workers that make up the support workforce.

Stephen Peckham: We will come back to that issue about development in a second, but Participant A?

Participant A:Yeah, just moving on from that point, the physician associates have filled, or been used to try and help fill, a demand in terms of medical physicians that work across lots of different sites but come under what the RCP oversees at the moment. I think they are great in terms of making

things look better as a plug, but it's not enough. You can't just keep saying, well, we're just going to add more physician associates, we're going to add more support workers, because actually you need to grow everything, and I don't think it's enough to just focus on another group moving in to help.

Stephen Peckham: In your experience and in the service, is there a bit of a disconnect therefore between the training planning and then the planning of workforce that's needed in the actual work?

Participant A: Massively, but HEE and locally employed doctors they're not all the same, are they? You have lots of doctors who are not under HEE guidance with the training number and people want progression, people are trying to get somewhere. I think you need a bigger overview of how people are getting to it, and I think there is going to be more non-standard progression with people trying to CESR and do different alternative ways into getting a consultant or associate specialist job or accepting your staff grade middle-grade rota… they haven't at the moment got grasp of what they want. They want headline captures.

Stephen Peckham: Because of the time as well, I just want to push that on a bit. So, if you've got a couple of brief comments, Participant D.

Participant D: Apprenticeships have been a real benefit, and certainly have shown us some real benefit in nursing for widening access to people who may not have access to professional qualifications and training, within our integrated care system we've seen significant benefit. The challenge with it is that there is no national commitment, I think somebody mentioned the organisations still have to provide all the salary support, so it's not a quick win, but it feels like the intention is to give money to… yes, you pull back your levy for training and you can plan more strategically with that as employers or systems, but the costs associated with release of those staff to actually undertake the apprenticeship are hugely challenging for providers who are already under scrutiny and cost improvement measures from a national perspective. They create more learners in the learning environment, which is great, but then the infrastructure is support the learners, – now there are apprentices, there are international nurses, there are student nurses - we do have to have more recognition and commitment to the infrastructure because there is limited national input for nurses, midwives, allied health professionals students, and certainly nothing for newly qualified professionals from a national level.

Stephen Peckham: OK, I think these are important points and they do move us in a sense to the whole area of building the workforce. The government said it was committed to ensuring that NHS clinicians and support staff develop the skills you need, and particularly there was the commitment in the community to go even faster to make sure that everybody is digitally connected, particularly community nursing staff and ambulance staff being connected to information and data networks. What's your experience in this area? Participant E, do you want to come in? It's the idea that in the ambulance services you will have the digital framework that would ensure you were linked into hospital systems.

Participant E: Yeah, it's not there Stephen because most trusts are only actually just coming off paper in the last couple of years, so we use System One but that's hit and miss as with the technology that's old in the back of the vehicles. We can't get data and we don't have a national database for violence and aggression. So, patients moving around from area to area or even town to town, we don't carry that information and unfortunately there's a missing need there of where that is. Just going back to what we spoke about earlier, the Carter Report for the ambulance service said there should be a paramedic on every ambulance and that went out in about 2016, that's never

going to happen. There is a lot of information in the Carter Report which again the commitments not there, we have not fulfilled what we're going to do.

Stephen Peckham: OK. Thank you, Participant C?

Participant C: I think one of the things in the laboratories that concerns us is that the ability of people to access the data that we have collectively striven to create. So, samples come from all over the place into laboratories, we produce the data and spend a huge amount of time trying to make sure they're accurate, and then the people who need them can't get at them. For example, I had a conversation with someone from RCN recently who works with NHS 111, and they can't access laboratory or primary care data. Similarly, I had a conversation with someone from the charity Equally Well who look after people with severe mental illness, and they've got huge problems accessing laboratory data because their patients don't want to come to places where the data is readily accessible. We have this huge connectivity issue, which means that patients get sent to hospital only for somebody to look at their data and send them home again, which cannot be a sensible use of anybody's resources, never mind the fact that people feel that they're doing work which the patients for whom they're doing it don't benefit. And that's a difficult one I think.

Stephen Peckham: Ok, thank you. Participant A?

Participant A: Having rotated so many times over these 12 years, mandatory training is different in every single trust and takes over a day to complete. Why? I'm not quite sure. The fire extinguisher in one is probably the same as a fire extinguisher in another. But if you're going to have a workforce planning issue, why are we not streamlining that to at least start things? Furthermore, primary and secondary care don't talk to each other on the same system; two hospitals in the same patch don't talk to each other because they all buy different digital operating services, whether it's Care Flow all Lorenzo, so you can't share things at all. Digital health is gone very much local based and not even just CCG based in terms of hospital based on whatever they bought from the cheapest thing.

Stephen Peckham: Ok. Any other comments about digital connectivity?

Participant C: Yeah, just on that one. There's a lot of push for people to have the same system. For me, this is never going to be achieved. What we could do is to have the systems talk to each other. If you think of the analogy of the traffic, we all drive about in different cars, but we all, we all have agreed that the wheel is on this side, the indicators go up and down and flash orange lights, the lights come on, the brake lights come on, the thing does what it does, and so we obey the rules of the road mostly. But the rules that we follow are consistent and allow us to travel quite effectively, all in different vehicles with different purposes that suit their needs. So is there logic, is there sense, is there reason in trying to get everyone to drive the same vehicle? Well, no. So why do we do that when we're trying to transfer information?

Stephen Peckham: Yeah, ok. Thank you, Participant B?

Participant B: Yeah, I just wanted to add on as well that many of our members are limited in their ability to collect or use data due to poor ICT equipment and inadequate web connections and we're calling for urgent investment in essential equipment, infrastructure and data skills training throughout the NHS workforce. In regards to hybrid working, the Chartered Society of Physiotherapy supports primary care and community health service initiatives to develop hybrid working practices for service delivery that are part of a personalised menu of options that will improve access, for example for people in rural areas, people who don't drive or have access to public transport and takes into account different communication needs and level of literacy. While we support the goal,

we have concerns about the timeline of the roll out of electronic patient records based on past experiences and challenges as well, and for those ICS's without functioning EPR at this stage it seems that it will be infeasible to go through the procurement, development, implementation, and training within the 20 months required to meet the target of 2024. This target is all the more ambitious for the additional target for population health management by 2025. So those are some of our key points around data.

Stephen Peckham: Ok, thank you. Do you think ICS will improve it? Does anybody want to comment on the changing infrastructure from that point of view?

Participant C: I think there is potential there, but it will require a lot of time, and time is of the essence, and it will require a lot of investment, and we do need to have principles in how we want to do it. So, there is potential in all these ideas but the realisation of them will be very complicated and take time to do because of the nature of what we're doing. The whole health service is a very complicated and complex organisation, and you tweak one bit and there's a ripple effect right away across that nobody in between even sees and it's very hard to predict what these are. So potentially yes, but it would be nice to try it perhaps.

Stephen Peckham: OK. I want to go back to and think a little bit about training, but in this sense, the continuing professional training or development training. A lot of you have highlighted problems of development, but you've also highlighted constraints on time and pressures on time. Are the opportunities for professional development there for staff? What are the problems in terms of accessing it or providing it? I think Participant D was first and then Participant A.

Participant D: Certainly from a nursing point of view, and I know it's nurses, midwives and health professionals, but from my perspective everything seems to be very short-term fire-fighting. From the funding perspective, as organisations trying to plan ahead to develop the appropriate opportunities to skill the workforce, for example, we have only in the last two years had CPD funding commitment from the government, which was a three-year commitment, which has made a difference, but unfortunately came over the pandemic when we couldn't actually hardly release anybody. However, in principle, that longer term commitment of what funding is available for CPD is the only way to ensure that we can appropriately plan and develop the workforce with the right skills and even, for example, this year, we're still waiting now in May to find out the funding – even though there's a commitment for 2020/23 for allied health professionals, nurses and midwives we don't know what amount that is or when we're going to get it. And this is in a good year. There's obviously concerns that, well what after this year? What after now? We cannot plan effectively for development of programmes and education, making sure we've got the right people of career pathways for appropriate roles, looking at our gaps; it's completely impossible to workforce plan to provide that appropriate development for staff. Certainly, for nursing, we need to be demonstrating attractive career pathways to retain and give particularly the early career nurses something to aspire to. At the moment it's very short term, there isn't a clarity of career pathways for things like clinical academic careers, advanced clinical practice. It's slightly improving because of the national strategy. Education, who's going to teach the learners of the future? Complete lack of clarity about how we're training and developing the workforce for that. So, I think there has to be some commitment to be clear what investment in CPD funding is there going to be moving forward for nurses, midwives and allied health professionals. Before CPD this last two years we used to get knowledge of the funding sometimes in August of a year when all courses start in September and then we're going into winter, so a complete inability then to release that during winter for development opportunities. That's really important – the ability to plan and professionalise the whole CPD agenda because it's certainly not there for nursing currently.

Stephen Peckham: OK. thank you, Participant A?

Participant A: Well, I'll just point out that as recently as last month study leave was cancelled for all consultants due to workforce pressures in my current trust. So, my if you want develop people, you've got to have a clinical environment so that they can be released for it. Second point: is there a need? Yes, but we need to work out what's going on. Remote consultations are a massive thing for the physicians going forward, what is outpatient working going to look like? No one's been trained in it. We've sort of had a go, we make a couple of phone calls and see what happens, but you've not actually got a CPD bit behind it. I think more and more frequently, our CPD is now online, and is that equivalent? Is that what you want it to be? It's losing all the networking opportunities, etc. I don't think it's actually much of a cost saving because most of things I can see it's about the same price to do it online.

Stephen Peckham: Is that because of the time that people take to do it?

Participant A: I think so.

Stephen Peckham: Ok, Participant C?

Participant C: Yeah, thank you. I think CPD is for career grade. Pathologists of all descriptions is a problem because there is a perceived lack of opportunity made available by employers for people to take. The sort of stuff that Participant A has been saying is absolutely resonant of what we hear. There are also difficulties in funding CPD and that's again left at individual employers to negotiate how much they're going to allow people in terms of time and money; although the consultant contract makes it quite clear what should be happening, it doesn't always happen. Whilst people like us in colleges are concerned about the wider aspects of career development, in terms of contributing to things like guideline writing which take a lot of time, and the Academy has recently secured agreement from NHS EI Chief Executive to write to trust chief executives to ensure that consultants are given the opportunity to partake of such broader work for the NHS; but that kind of work is really important because it involves everybody in the care pathways and it helps us deliver better quality care. We have a very short-term view on CPD thinking, it's necessary to tick a box for appraisal, but in fact that's only the recording of it. What we're trying to do is to develop our learning to enable us better to do what we do, to make patient journeys smoother, better, faster and more effective. So, there is a disconnect between the rhetoric and the reality.

Stephen Peckham: Thank you. Participant B?

Participant B: Yeah, just a few points around development and training. In regard to career pathways, this needs to be taken by employers and seriously to ensure the proportion of the physio workforce with certain protected characteristics in senior roles should be equivalent to the proportion of those in less senior roles, like for doctors and nurses as well. At present in England, unlike Wales, there's no requirement to include AHP directors at board-levels within trusts or ICSs, and we believe AHP's together with doctors and nurses at board-level in trust will have a significant improvement to the local workforce, to national workforce, and to workforce planning as well. A lack of directors at this level creates a glass ceiling for physios and other AHP's and limits the input of AHP's into the workforce strategy planning. In regard to placements, we've seen our expansion in high quality accredited university courses nationally. There is sufficient placement capacity within the system to grow, but the capacity can only be released if all teams take in students in all settings. In regard to advanced practitioners, the most pressing need for advanced practitioners roles are in primary and community sectors. There is an urgent need for advanced practitioner roles to lead the expansion and quality improvement urgently needed in community rehab services for example. The

Chartered Society of Physiotherapy would like a career framework that develops physios from being new registrants on to becoming advanced practitioners. As well as providing the pipeline needed for advanced practice roles, this will support the retention of the workforce in regard to those who are joining and who see that career path and progressing in the NHS. We would like to see the shortened timeframe from when new graduates join to developing advanced practice skills. Currently around 10-15 years, to 7-8 years. Currently because of the lack of opportunities people get stuck within roles in the NHS and often leave the NHS to work as physiotherapists in other sectors. And also, as I said in regard to FCP's to achieve the long-term plan we need advanced practice skills in first-contact roles. Developing physiotherapists into these roles is the only way that the target for 5050 FCPs can be met.

Stephen Peckham: Thank you, Participant B. Some of you have mentioned the importance of that in terms of retention of staff and presumably that's around the way I think, Participant C, you described it as the culture and wellbeing of staff members. There have been commitments around improving wellbeing, mental health support and action on bullying. Has that been something you've seen in your work practice and is access to these supports better? Or is it more about things like investing in staff for retention? I think, Participant A, you're first.

Participant A: I think I answer a different question each time when I'm asked about bullying or undermining, it needs to have a standard way of asking about it, because you can change the figure depending on how you answer the question. Secondly, you keep asking it and it doesn't seem to change, so I think eventually we're going to have survey fatigue, and in terms of doctors the GMC surveys and training etc is something we have to do to get through the year; but actually, you don't have to do it – in the South West I think we've got the lowest uptake of 37% who actually filled it in this year. So, if you're going to keep asking about it, do something with the data rather than just ask us again to see if it's got any better because it has not. In terms of wellbeing, there has been money put aside for wellbeing, but I don't think a yoga class is going to suddenly make the pandemic go away and what we've had to deal with, and actually addressing the problems and the fact you're working 120% of what a normal contract is or working 150% of what a normal contract is would probably be a better way than making me come in on my own time to do a yoga class.

Stephen Peckham: Ok. Participant C, you, you brought this up earlier and we have just been reminded that we have 10 minutes left, so yeah.

Participant C: Well, I'll try and be as brief as I can. A lot of this is about behaviours and the fact that we're not nice to each other and I think there is evidence that the pandemic has increased the amount of bad behaviour. There's evidence that kindness and politeness, where it has been looked at clinically in surgery, improves patient safety. And I think there's a good reason why we all should be. A lot of that is couched into the language that we use; we use different language sets for members of staff then we do for patients, and if you want a comparison look at the NHS England Patients Charter and compare that to the wording of the gold guiding for training- "A Reference Guide for Postgraduate Foundation and Speciality Training in the UK"- just flip the words around and it's really interesting to see what's happening there. There is no way you would speak to patients the way that we speak to junior doctors in regard to training in the documentation that we put out for training in the NHS and medicine. So, I think that's a really important piece. When it comes to wellbeing, yes there's stuff being done about wellbeing, but we now have to do wellbeing, like we have to do compulsory training like moving and handling and putting out fires and stuff, so it's become another tick-box exercise, 'go and sit under a tree for a while and you'll feel better', well no I won't because I'm conscious of the fact that when I go back all this stuff I didn't do while I was under the tree is still there to do. So, there's a lot of this stuff that we have to do is about cultures,

and that's about making it a nicer place to be, to have a shared set of values where we value each other and where we feel valued, and where we feel heard and listened to by the managers and others in authority in healthcare. And part of that is about the environment within which we work. Many of us, particularly in laboratories in my experience have leaky roofs, buildings that are not fit for purpose, I know one pathology department that's an old flat that somebody used to occupy. This is unacceptable, and the facilities that people have to work in and are also relevant here. So, there are a whole load of things in there about health of staff, the wellbeing of staff. There was a lovely report produced by the GMC written by Michael West and Denise Coia around the importance of looking after doctors to deliver good care to patients. That's generic and we just don't do it so. It's very wide ranging, it involves a huge amount of stuff, but it's largely around about behaviours, facilities and language; and I do think that improving workplace culture would make a big difference to the retention of others and how we can accommodate all the words that people have used like flexibility and appreciation, all these things come into this.

Stephen Peckham: Thank you, Participant C. Both Participant D and Participant E, you mentioned retention. Participant D?

Participant D: I think what Participant E was saying about things like late career retention, we can't underestimate the impact of the COVID pandemic on absolute physical and mental wellbeing of staff and those people that can go are now absolutely thinking they're going. What we've noticed is newly qualified staff are even are now coming looking for part-time contracts, I think somebody else mentioned that earlier, so not even wanting to apply for a full-time job in the first place at all. So what impact is that having on the workforce numbers? There's a risk that wellbeing starts getting seen as a bit of a tick-box word rather than a meaningful action truly looking after staff, because it does sometimes feel like all the people promises are over here and yet all the pressures on clinical services and the demands for elective recovery and targets for this, that, and the other, they seem to be at loggerheads with each other when you're trying to do that on the front line. We have either got to properly look after staff and commit to do that and their wellbeing, and develop them, and truly value them, or we are going to lose more, and we will not attract people to stay. I'm seriously concerned about that late career retention, it's not attractive anymore.

Stephen Peckham: Thank you, Participant D. Participant E?

Participant E: Yeah, I can echo everything that's been said, and I agree with what Participant D said about culture. I am a union rep as well as my clinician role and I find that the amount of complaints I actually get through is not necessarily the patient to paramedic, it's actually paramedic to management, and we've got a massive issue within the culture of ambulance service for the bullying and actually it is coming top-down. And what we're really good at as a service is then moving that problem about so we can quite easily move the head of operations to head of operations at another ambulance trust knowing that we've got a culture of bullying and harassment. We're quite good at moving that senior management around which again creates distrust, because we're all aware of that issue and within a three-year period that manager has gone in and done exactly the same at another ambulance service and left demoralised staff. We're very good at moving issues about and I don't know how we resolve that, Stephen. But we've put quite a lot into wellbeing, and again, I found that to be a tick-box is exercise, I've still had colleagues in the last 12 months which I have for the last 20 years committing suicide and I don't think we'll get away from that. I actually think we're on the brink of having a lot more, I don't know if Participant A and Participant D see that with their colleagues, but I'm expecting a massive increase this next this next year, it's coming, and I don't know what we do about that.

Stephen Peckham: There are supposed to be additional support services in terms of access to mental health support and also musculoskeletal support, which is probably a good thing to talk to Participant B about. Is that one of the areas that is actually a problem in terms of providing it as well?

Participant B: Before I come on to that point, I just wanted to briefly touch on one of the issues around retention. Which is, firstly, our latest staff survey data indicated that only 35% of physiotherapy respondents are satisfied with their level of pay, 3/10 physiotherapy staff now often think about leaving their employer with careers outside of the NHS increasingly identified by leavers as their most likely destination. Physiotherapists and other health unions are calling for urgent action to stem the tide of staff leaving the health service, it's not enough to recruit new staff, and action must be taken to retain existing staff as well. We believe staff deserve a decent pay rise. But in regard to bullying and harassment and also mental health can cost the NHS more than £2 billion a year, and the impact on staff is a greater risk of human error and poorer patient reduced productivity. We work closely with the Social and Partnership Forum to put together policies and agreements with employers, and what organizations can do is promote the NHS EI civility and respect toolkit to meet the people plans vision and create policies to develop and promote a positive culture. What managers can do is identify, as colleagues have said, early warnings and challenge inappropriate behaviours. In regard to mental health, we believe more needs to be done to tackle the root causes of workplace stress and ill health and physiotherapy workforce rather than relying on an individual's resilience. Due to increasing demands on healthcare services and the pandemic, the levels of fatigue, exhaustion and emotional fragility amongst members are understandably very high. Members tell us that levels of anxiety and stress have significantly increased during the pandemic and it is clear that people will experience different emotions at different times as well. In regard to mental health and wellbeing, we believe you need the government and NHS, and also, they need to expand the workforce, take full advantage of the growth of physiotherapy, increase capacity and community and primary care teams.

Stephen Peckham: Can I just draw you to a close? I'd like to let Participant A in, if that's ok, we could disappear any second now. But I think I got the points about expanding workforce and taking stress off of people is the way to do it, I think a number of you said that. So, we may disappear, but thank you everybody for your input. Participant A?

Participant A: Very, very quickly. Working in respiration and ICU through the pandemic, a lot of my friends are senior registrars and junior consultants have had problems and have approached people for support. A lot of it is charities, a lot of it is individuals who reached out during the pandemic, and just to say that that the psychologists have been embedded in a lot of units, but there isn't enough of health psychologists to go round. And actually the trim stuff and the stuff in the ICU shows that the people who are actually on the fringes of a trauma environment are actually the ones most affected, sometimes it can be the cleaner that witnessed the major trauma and that has the most effect on them. So, we've invested quite heavily in doctors, but there's also a whole lot of other people in the hospital that probably experiencing some horrible things as well and there isn't really an NHS place for that. It's picked up by charities at the moment.

Stephen Peckham: Alright, thank. Thank you everybody for your input. It's been really interesting.

Participant C: Thank you very much. I guess just finally in response to the questions, the answer is no to meeting all the commitments, which is kind of interesting, but I think we have ideas as to how we could fix it, perhaps, at least attempt to, which is something.